

AAMC Statement on the Physician Workforce

June 2006

Background

An appropriate supply of well-educated and trained physicians is an essential element to assure access to quality health care services for all Americans. The 2006 AAMC Position Statement on the Physician Workforce updates and revises prior statements. These positions are intended to better assure an appropriate supply of physicians while increasing medical education opportunities for Americans.

In the 1980s and 1990s, workforce analysts and public policymakers, with few exceptions, predicted the United States would experience a substantial excess of physicians by the beginning of the 21st century. In light of these studies, the AAMC and other national organizations recommended steps to reduce physician supply in order to obviate the predicted surplus. Over the past two decades, enrollment at allopathic medical schools has been essentially flat.

It is now evident that those predictions were in error, in part because of the assumption that managed care would drastically change the way that healthcare is organized, and delivered. The year 2000 has come and gone, and there is no convincing evidence that the current supply of physicians exceeds the demand for physicians' services. Mounting analytical work, as well as anecdotal evidence, suggests that current trends will culminate in a shortage of physicians within the next few decades, absent fundamental changes in the demand and need for healthcare and/or in the way healthcare is provided. Indeed, there have been a growing number of specialty and state specific studies concluding that shortages exist or will soon exist in particular specialties or states.

The AAMC believes that sufficient evidence is at hand to recommend that entry level positions in both U.S. medical schools and GME programs should be increased over the coming decade. This conclusion is bolstered by the realization that a shortage of physicians would undeniably make access to care more problematic for all citizens. Such shortages would increase the delays individuals encounter in scheduling appointments and the distances they will need to travel for various types of healthcare services. Shortages would be especially problematic for the disadvantaged who already encounter substantial barriers to healthcare services. It is further recognized that, given the extended time required to increase U.S. medical school capacity, and to educate and train additional physicians, the nation must begin to increase medical school and GME capacity now to meet the needs of the nation in 2015 and beyond.

A variety of factors affect the reliability and future validity of projections of future workforce needs. First and foremost among these variables are the structure and dynamics of the overall healthcare delivery system. A legitimate concern is whether the recommended increase in medical school and GME capacity will be required if there is a fundamental change in the way health care is delivered. While this is certainly possible, the Association has concluded that the recommended increases are necessary because the best information currently available clearly projects a shortfall for meeting the basic physician workforce needs in the current system. If the system were to change dramatically enough to modify this projection it is anticipated that adjustments in total entrants to the workforce could be undertaken either through reductions in the number of Foreign Medical Graduates (FMGs) that enter the United States for graduate training and/or deferral of planned expansion at U.S. schools.

Beyond the delivery system, the Association recognizes that there is an ongoing need to better understand the other forces that affect the supply of and requirement for physicians. A vigorous effort

should be undertaken to identify relevant trends and forces that impact the likelihood of either an excess or shortage of physicians in the future and to monitor these trends on a regular basis. This effort will require creative research initiatives to determine, among other factors, how people use physicians' services over time, the impact of changes in the composition of the physician workforce, and how physician productivity changes over the course of a career. Future studies also should focus, more than studies have historically, on the influence of market forces, of economic incentives and disincentives, of the increasing use of information technology, the role of non-physician providers and local variations in the impact of these and other variables. To assist in clarifying these important issues, the association has recently established the AAMC Center for Workforce Studies.

Physician Workforce Principles

1. The AAMC is committed to promoting an adequate supply of well-educated physicians sufficient in number to meet likely future needs of the United States.
2. The AAMC recognizes that the nation's physician workforce comprises physicians educated at allopathic schools, osteopathic schools and schools outside the U.S. and that these schools will continue to contribute importantly to meeting the health care needs of the United States.
3. The AAMC believes that schools accredited by the Liaison Committee on Medical Education (LCME) and graduate medical education programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) provide the best structure and process to assure that physicians receive a comprehensive medical education. Allopathic medical schools and their affiliated teaching hospitals function as critical sources of research, new medical knowledge, and cutting-edge clinical care, and as a vital part of the nation's medical safety net. Together, these functions provide an optimal environment for medical education.
4. The AAMC believes that the vast majority of licensed physicians in the U.S. should be educated and trained in allopathic schools and graduate programs and that these programs deserve strong public support.
5. The AAMC supports efforts to improve medical education and health care throughout the world and therefore continues to support the provision of training opportunities for individuals from all nations. It supports worldwide efforts to minimize the dependency of the United States and other countries on health care providers from less developed nations.

Workforce Recommendations

1. Enrollment in LCME-accredited medical schools should be increased by 30% from the 2002 level over the next decade¹. This expansion should be accomplished by increased enrollment in existing schools as well as by establishing new medical schools.

¹ In 2002 there were 16,488 new matriculants in allopathic medical schools. A 30% increase is equal to an additional 4,946 matriculants per year. This would require 21,434 new matriculants in 2015.

The United States medical education community has spent decades developing standards and methods to help assure that schools meet appropriate minimum standards and that physicians that graduate from these schools have the skills and knowledge necessary to provide high quality care. The nation is better served when a greater, not lesser, proportion of future physicians are held to these standards. Moreover,

- There are large numbers of Americans who aspire to attend U.S. medical schools but have been unable to gain admission due in part to limited capacity. Many are so committed that they are willing to pay high tuitions at schools with varying standards and leave the U.S. for several years to reach their goal;
- There is growing international concern that English-speaking countries may be draining valuable human resources from less-developed countries.² Increasing U.S. medical school graduates will reduce the “pull” of physicians from less developed countries without creating barriers for individual migration.

Achieving the desired growth in allopathic graduates will require an increase in enrollment at most existing medical schools as well as new medical schools. Increases in enrollment are particularly appropriate in areas of the country where the population has grown rapidly over the past 25 years and areas where the population is projected to grow rapidly in future years. In addition, states with low medical school enrollment per capita, with numerous underserved areas and states with large and growing elderly populations may also be appropriate areas for medical school enrollment growth.

The Association recognizes that the education of future physicians is protracted and complex. The costs incurred are offset by a wide array of funding sources, including students and their families, school-specific funds, government, and philanthropy. Medical school expansion will require stable short and long term funding, and assistance may be required from state governments and appropriate federal agencies.

2. The aggregate number of graduate medical education (GME) positions should be expanded to accommodate the additional graduates from accredited medical schools.

U.S. medical schools face many challenges in increasing the number of medical school graduates. A primary goal of this expansion is to increase the supply of physicians available in order to assure access to services in the future. Since all physicians must complete accredited graduate training to become licensed in the U.S., the number of GME positions must also be increased for an expansion in U.S. medical school graduates to lead to an increase in physicians available to care for Americans.

For graduate medical education, in addition to stabilizing the current support mechanisms, the current Medicare restriction on the number of funded residency positions must be eliminated so that sponsors of graduate medical education can respond to changes in medical school enrollment and other physician workforce market dynamics. The AAMC should continue its efforts to educate the public and policy makers about the impending physician shortage and the importance of eliminating the Medicare restrictions on the number of residents that will be supported to ameliorate these shortages.

² See for example: Mullan F. The Metrics of the Physician Brain Drain. *NEJM* 2005 353: 1810-1818.
World Health Organization: The world health report 2006 - working together for health. Geneva: WHO; 2006.

3. The AAMC should assist medical schools with expanding enrollment in a cost effective manner; assuring appropriate medical education for traditional and non-traditional students; and increasing the number and preparedness of applicants.

While there are barriers to increasing medical school enrollment that need to be addressed by individual schools, there are a number of activities that AAMC can undertake to assist its members. These include the following:

AAMC should identify, evaluate and pursue strategies that:

- Provide efficient and effective medical education that promote medical education innovations and that evaluate alternative approaches to expanding capacity; and
- Improve and increase the pool of U.S. medical school applicants, including marketing medicine as a career and expanding outreach to qualified students who currently do not apply.

AAMC should identify best practices and disseminate information on these practices to member institutions.

4. The AAMC should continue to advocate for and promote efforts to increase enrollment and graduation of racial and ethnic minorities from medical school; and promote the education and training of leaders in medical education and health care from racial and ethnic minorities.

Studies have repeatedly shown that medical students from racial and ethnic minority groups are more likely to practice in under-served communities and to care for a disproportionate number of disadvantaged patients. This information, coupled with other compelling arguments, underlies the AAMC's strong advocacy for greater diversity in medical education. The implementation of lawful, race- and ethnicity-conscious decision making in medical school admissions and in faculty recruitment and retention is essential to meet society's need for a physician workforce capable of caring optimally for our increasingly diverse population.

5. The AAMC should examine options for development of: (1) a formal, voluntary process for assessing medical schools outside the U.S.; and (2) a mechanism for overseeing the clinical training experiences in the U.S. of medical students enrolled in foreign medical education programs.

Several factors are stimulating increasing concern about the quality of foreign medical schools that send significant numbers of their graduates to the U.S. for post-graduate training and/or medical practice. At least 20 medical schools, many of which are proprietary, have been established primarily to educate U.S. citizens in countries that lack an accreditation process comparable to that of the LCME and that have little or no capacity to provide oversight of medical education. In addition, such schools often send third- and fourth-year medical students to hospitals or other clinical settings in the US for their required clinical training, and advertise such outside clerkships in their recruitment materials. While there are no data on the number in clinical clerkships in the United States, about 2,400 United States FMGs applied each of the last two years for Educational Commission for Foreign Medical Graduates (ECFMG)

certification; thus, there may be as many as 5,000 students from foreign schools in clerkships each year. Such clerkship arrangements are negotiated entirely between the administrative authorities of an individual hospital or clinical site in the U.S. and the offshore school and typically include payment to the clinical site on a capitation basis. Anecdotally, a few such arrangements are beginning to compete with LCME-accredited programs in the U.S. for clinical training sites. Only a handful of states regulate these clerkships in any way.

The scope of accreditation of the LCME is and has been limited to medical education programs leading to the MD degree that are legally authorized in and conducted in the United States or Canada. Extension of the process of LCME accreditation to foreign schools poses a number of concerns including: (1) applicability of some LCME accreditation standards to programs in other cultures and health care delivery systems; (2) uncertainty about legal protections in foreign jurisdictions should the LCME deny or withdraw accreditation to a foreign program; (3) development of a financing process for assessment of foreign programs that would insulate the LCME's sponsoring organizations from unbudgeted costs; (4) identification of a suitable pool of qualified surveyors, especially with respect to language and culture issues, without undermining the surveyor pool for the LCME-accredited schools; and (5) impact for other physician credentialing agencies in the U.S. that have already established LCME accreditation as the gateway for eligibility to graduate medical education and licensure.

The AAMC should convene a working group to explore options for formal assessment of quality of medical education programs, including consideration of standards, financing mechanisms, incentives for participation by foreign programs, especially those that educate predominantly U.S. citizens, and impact on graduate medical education, licensure, and AAMC members. Consideration should also be given to mechanisms that could be implemented to monitor and regulate the quality of clinical clerkships provided for medical students from non-accredited medical schools, and the impact of such clerkships on the educational programs of LCME accredited U.S. medical education programs.

6. AAMC should take a more active role in supporting and assisting associations of medical schools in other countries, especially in less developed parts of the world. AAMC should work with its members to expand collaboration between medical schools and teaching hospitals in the U.S. with those in less developed countries.

The AAMC and its members have valuable knowledge, skills and resources that would be of great help to the medical education community in less developed countries. Many AAMC members have already begun to work with institutions and organizations outside of the U.S. An expansion of this activity would not only assist less developed countries but would also indicate the commitment of the United States medical education community to improve health worldwide. The AAMC is in a unique position to coordinate and promote efforts among its members.

A program to encourage and support opportunities for U.S. medical students, residents and physicians to spend time in less developed countries could help less developed countries and would be of educational value to US physicians. A bill was introduced in Congress in 2005 to establish a Peace Corps type program for physicians. The AAMC should monitor and potentially support this type of program.

7. The J-1 visa is the most appropriate visa for non-U.S. citizen graduates of foreign medical schools entering graduate medical education programs in the U.S. and should be encouraged.

The primary purpose of graduate medical education is education. The J-1 program's purpose is educational and its administration by the ECFMG assures that J-1 residents and fellows possess valid educational credentials, have successfully passed Steps 1 and 2 of the USMLE, and that their country of origin needs the knowledge and skills that they will obtain through their education in the U.S. No other immigration program or visa category is as consistent with the aims of U.S. graduate medical education or offers an equal assurance of the quality of entrants.

The H-1 visa (an employment visa) is not appropriate for physicians coming to the U.S. for education and training purposes. At the national level, the AAMC should pursue clarification, and a potential expansion, of the types of visas available for physicians seeking GME in the U.S.

8. The AAMC should undertake a study of the geographic distribution of physicians and develop recommendations to address mal-distribution in the U.S.

Increasing the supply of physicians in the United States will not in and of itself address the problems of geographic mal-distribution nor can this problem be solved primarily through medical education interventions. The AAMC should undertake a study to identify strategies to address mal-distribution.

Many rural, urban and racial and ethnic minority populations are likely to remain medically under-served for the foreseeable future, and certainly will be so if a national physician shortage emerges. Given this reality, the AAMC should work with other organizations to determine, utilizing the results of this study and other resources, the best means to address the problem of inadequate access to physician services and the geographic mal-distribution of physicians. Consideration should be given to expanding the opportunities for young physicians to practice in under-served areas and in institutions serving under-served and disadvantaged populations.

9. National Health Service Corps (NHSC) awards should be increased by at least 1,500 per year to help meet the need for physicians caring for under-served populations and to help address rising medical student indebtedness.

The NHSC has played an important role in expanding access for under-served populations in rural and inner city communities, and continued expansion of this program is strongly recommended. The NHSC is an existing program with a proven track record of supplying physicians to underserved areas. The growing debt of graduating students is likely to increase the interest and willingness of U.S. medical school graduates to apply for NHSC funding and awards. The adequacy of current award funding levels should be assessed to assure that they are adequate to attract physicians to the NHSC in light of growing student debt.

An increase of 1,500 awards each year would greatly increase funding for medical students and encourage individuals to apply for medical school. Each year, as many as 1,500 waivers are available for physicians with J-1 visas that permit them to waive the requirement that they return to their country of origin in return for serving in an underserved area of the U.S.

10. Studies of the relationship between physician preparation (i.e., medical education and residency training) and the quality and outcomes of care should be conducted and supported by public and private funding.

There is a lack of empirical evidence of the relationship between medical preparation (education and training) and the quality of care. While it is presumed that more comprehensive education and training better prepares a physician to provide high quality of care, there have not been studies to confirm this. It is also possible that certain types or elements of education and training may have a greater impact on some physician activities than other activities. Given the national concern with quality and outcomes, additional resources should be invested in research in this area.

11. Ongoing and stable funding should be provided to track the physician workforce, including monitoring the supply of, and the demand for, and the contributions made by FMGs.

These collective efforts must include timely collection and dissemination of workforce information, including how the physician workforce is constituted; where physicians provide care; economic and non-economic factors influencing the decisions of students and practicing physicians about where and how to practice; differences in practice patterns across various regions and local markets; and the role of the large number of foreign medical school graduates entering the U.S. health care system. In addition, further study is needed to identify strategies to retain physicians in the workforce and to enhance the efficiency and effectiveness of physician services.

Foreign medical graduates represent about 1 in 4 physicians actively practicing medicine in the United States and a quarter of all physicians in training in this country. They clearly are an important resource but more information and data are needed to better understand the contributions of FMGs. Tracking and understanding the role of FMGs will help in formulating effective policies related to FMGs as well as access and quality of care.

12. Individual medical students and physicians should be free to determine for themselves which area of medicine they wish to pursue and GME programs and teaching hospitals should be free to offer training in specialties they wish to offer if accredited by the ACGME. The AAMC should provide students, physicians, programs and hospitals with the best available and timely data on physician workforce needs in order to support informed decisions. The AAMC should support efforts to promote a healthcare delivery and financing system that can better align marketplace demand for physicians with health care needs of the population.

To facilitate individual choice, medical students and physicians must have up-to-date and comprehensive information, such as information on current and future professional opportunities as they make specific plans about their future career paths. Having such information is not only in the interest of individual students, it is essential in a free society for ensuring the preparation of a physician workforce capable of meeting the needs of the nation.

In addition, residency programs and teaching hospitals also need to have information on the likely future supply and demand for physicians so they can make better decisions regarding the size, scope, and specialty of residency training.

The AAMC, through its Center on Workforce Studies is committed to assessing the supply and demand for physicians and to encouraging research to help inform the medical education community, including students, as to likely future physician workforce needs. In addition, the AAMC, individual medical schools, specialty societies, and sponsors of graduate medical education programs should collaborate to provide the most relevant information through mechanisms such as the AAMC's Careers in Medicine program. In addition, medical schools should ensure that students have adequate experiences in, and/or balanced information about, all specialties.

Although the AAMC believes that specialty choice should be left to individual medical students, physicians, and teaching programs, the Association recognizes the shortcomings of the current marketplace and health care system including the continuing shortage of generalist physicians. Therefore, AAMC supports efforts to study the financing and delivery system and to better assure that the incentives and rewards of the financing and delivery system are more consistent with the nation's health needs.

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